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No. 99-1815

IN THE
Supreme Court of the United States

NATIONAL LABOR RELATIONS BOARD,
Petitioner,

v.

KENTUCKY RIVER COMMUNITY CARE, INC., *et al.*,
Respondents.

On Writ of Certiorari
to the United States Court of Appeals
for the Sixth Circuit

BRIEF FOR SOCIETY FOR HUMAN RESOURCE MANAGEMENT AND AMERICAN SOCIETY FOR HEALTHCARE HUMAN RESOURCES ADMINISTRATION AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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STATEMENT OF *AMICI* INTEREST[1]

The Society for Human Resource Management ("SHRM") is the largest human resource management association in the world. SHRM provides education and information services, conferences and seminars, government and media representation, online services and publications to more than one hundred fifty thousand (150,000) professional and student members throughout the world. Of these 150,000 members, 9,116 self-identify as members of the health care field. The American Society for Healthcare Human Resources Administration ("ASHHRA") consists of over 3,000 members, and is the only membership organization in the United States dedicated exclusively to the field of professional health care human resources management. ASHHRA leads and serves by providing its members with information, education and legal and professional updates. The instant matter is of interest to SHRM and ASHHRA because both believe that the National Labor Relations Board's ("Board's") application of 29 U.S.C. § 152(11) [hereinafter "Section 2(11)"] in nurse-supervisor cases is an incorrect interpretation of the National Labor Relations Act ("NLRA" or "Act") that has, and will continue to, negatively affect the provision of health care in this country.

INTRODUCTION AND SUMMARY

The instant matter involves important public policy issues regarding the structure of the nation's health care delivery system and an important statutory construction question under the Act. In a series of recent cases involving the question of whether nurses are supervisors under the NLRA, the Board has misapplied the Act's definition of supervisor. Under Section 2(11), an employee is a supervisor if 1) he or she has the

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[1] Counsel for all parties have consented to the filing of this brief, and their consents have been filed with the Clerk of this Court. No counsel for either party had any role in authoring this brief, and no other person other than the named *Amici* and their counsel has made any monetary contribution to the preparation and submission of this brief.

authority to engage in one of twelve statutorily stated activities; 2) the employee exercises such authority in the interests of the employer; and 3) the exercise of the employee's authority is not routine or clerical but involves the use of independent judgment. In nurse-supervisor cases the Board has interpreted and applied this definition in such a manner as to deny nurses Section 2(11) supervisor status as a matter of course, to extend coverage of the Act beyond the limits defined by Congress, and in a manner that will adversely impact the ability of health care providers to effectively deliver quality care to patients.

SHRM and ASHHRA respectfully request that this Court, as it did in *NLRB v. Health Care & Ret. Corp.*, 511 U.S. 571 (1994) (hereinafter *HCR*), affirm the United States Court of Appeals for the Sixth Circuit's correction of the Board's "'unique' misapprehension of the manner in which § 2(11) applies to nurses." *Integrated Health Servs. of Mich., Inc. v. NLRB*, 191 F.3d 703, 707 (6th Cir. 1999) (citing *Caremore, Inc. v. NLRB*, 129 F.3d 365, 371 (6th Cir. 1997)). As this Court has recognized, Congress enacted Section 2(11) to ensure to employers the complete loyalty of those employees who serve as supervisors. *See Florida Power & Light Co. v. Int'l Bhd. of Elec. Workers, Local 641*, 417 U.S. 790, 807 (1974). Congress considered such loyalty essential to maintain the balance of power in the workplace between unions and employers. *See id.* at 811. Congress' concern in this regard is no less applicable in the health care context. Indeed, as this court recognized in *HCR*, "the statute gives a nursing home the ability to insist on the individual loyalty of its nurses" when such nurses act as supervisors. *HCR*, 511 U.S. at 580-81.

Notwithstanding the policies behind Section 2(11), the Board's current approach to the section routinely denies nurses supervisor status, despite the fact that in today's nursing-home environment, as well as in other aspects of the health care industry, many nurses are employed in roles that require the

continual exercise of independent judgment in a variety of supervisory tasks that are critical to the provision of quality care.[2] Indeed, many of these supervisory judgments dramatically affect the health status of patients, and may even involve matters of life or death. Nurses in various health care settings give minute-to-minute, let alone hourly or daily, supervisory instructions to other nurses, technical employees, aides, orderlies, and clerical employees.[3] The nature of this decisionmaking is as varied and complex as is the often-changing nature of a patient's medical condition. Indeed, in light of these workplace realities, SHRM and ASHHRA submit that the Board's current application of Section 2(11) in nurse-supervisor cases cannot be squared with the language, purpose, or history of the section.

The Board's approach in this area also represents poor public policy. If the Board's present approach with respect to the classification of nurse supervisors is left unchecked, long-term-care facilities and acute-care hospitals will not have a sufficient number of supervisory nurses to effectively and

---

[2] SHRM and ASHHRA acknowledge that the determination of supervisory status under Section 2(11) requires, among other things, a detailed application of the facts of a particular case to the applicable statutory criteria. Thus, SHRM and ASHHRA do not ask this Court to announce a per se rule defining which classification of nurses are supervisors for the purposes of the NLRA. Nevertheless, as was recognized recently by the United States Court of Appeals for the Third Circuit, and is detailed in this brief, "similar organizational structures exist throughout the nursing home industry." *NLRB v. Attleboro Assocs.*, 176 F.3d 154, 163 (3d Cir. 1999)

[3] Iowa Nurses' Ass'n, *Nurses and EMS Personnel: Collaboration, Delegation and Accountability*, http://www.iowanurses.org/nurseems.htm (last visited Dec. 7, 2000); Agency for Healthcare Research And Quality, *Long-Term Care: Experts Recommend Minimum Nurse Staffing Standards for U.S. Nursing Homes*, at http://www.ahcpr.gov.research/jun00/0600ra14.htm (last visited Dec. 21, 2000)

efficiently manage and direct the delivery of many health care services. The impact of the Board's approach will be particularly difficult for health care providers, given the cost-containment pressures that increasingly are placed upon such institutions. Establishment of innovative managerial structures with appropriate nurse supervisory models is critical to the development of a more efficient health care delivery system. However, by routinely denying nurse supervisors Section 2(11) supervisory status—and thus permitting the unionization of such nurse supervisors—the Board's approach to Section 2(11) severely compromises the health care employer's ability to select, control, compensate[4] and ensure the ultimate loyalty of such individuals.

The critical irony and end point of the Board's approach to the instant issue is that under federal labor law, Section 2(11) supervisory status will be more easily and more frequently established in virtually any industry other than health care—although it is in health care, however, where the lack of appropriate nurse supervision can result in the loss of life or long-term, severe medical consequences for the patient and corresponding significant financial liability for the employer.

[4] This is particularly true in the area of incentive and merit compensation. *See McClatchy Newspaper*, 321 N.L.R.B. 1386 (1996), enf'd 131 F.3d 1026 (D.C. Cir. 1997).

ARGUMENT

I. NURSES INCREASINGLY PERFORM CRITICAL SUPERVISORY FUNCTIONS RELATED TO THE PROVISION OF PATIENT CARE THAT REQUIRE INDEPENDENT JUDGMENT.

A. MANY NURSES ENGAGE IN THE SUPERVISORY FUNCTIONS LISTED IN § 2(11) OF THE NLRA.

It is beyond question that many nurses in today's health care workplace exercise significant supervisory responsibilities. RN duty and job descriptions aptly illustrate this point. According to the North Carolina Nurses Association, it is the RN's job to "direct and supervise nursing support personnel such as LPNs." North Carolina Nurses Ass'n, *RN Education, at* http://www.ncnurses.org/ rneducation.htm (last visited Dec. 7, 2000). For instance, in the field of emergency care, it is well established that "'[a]ll non-RN caregivers, involved in providing nursing care . . . [are] directly supervised by and responsible to professional emergency registered nurses."[5] In the area of home-based health care, federal Medicare regulations permit LPNs to provide nursing services in patients' homes, *but only* so long as LPNs, and any unlicensed aides, are "under the general supervision of registered nurses." Nat'l Ass'n for Hospice Care, *1999 NAHC Legislative Blueprint for Action*, L112 *at* http://www.nahc.org/NAHC/LegReg/99bp/legblue4.html (last visited Dec. 7, 2000). Finally, in the nursing home area, RNs typically act as on-site administrators. *See Long-Term Care: Experts Recommend Minimum Nurse Staffing Standards for U.S. Nursing Homes, supra*, note 2. "Although the exact job

[5] Iowa Nurses' Ass'n, *Nurses and EMS Personnel: Collaboration, Delegation and Accountability, at* http://www.iowanurses.org/ nurseems.htm (last visited Dec. 7, 2000).

titles vary from facility to facility, the primary hierarchy for nursing homes is: RNs serving administrative and management roles, LPNs serving combined roles as charge and treatment nurses, and CNAs working under the direction of LPNs, taking care of the residents' basic daily needs." Jonathan Edward Motley, Note, *Grandmothers and Teamsters: How the NLRB's New Approach to the Supervisory Status of Charge Nurses Ignores the Reality of the Nursing Home*, 73 Ind. L. J. 711, 717-18 (1998).

The descriptions from all of the various nursing fields demonstrate one common theme: that many nurses shoulder the authority and responsibility for supervising other nurses and non-licensed health care personnel. Health care employers hire nurses, not merely to act as conduits for the dictates of protocols and procedures, but rather to exercise independent judgment in numerous respects, including the supervision of other employees.[6] *See Beverly Cal. Corp. v. NLRB*, 970 F.2d 1548, 1553 (6th Cir. 1992) ("It is perfectly obvious that the

[6] In Kentucky, the site of the instant case, the ability of a Registered Nurse or a Licenced Practical Nurse to delegate nursing tasks to assistants is governed by statute and administrative regulation. *See* Ky. Rev. Stat. Ann. § 314.011; 201 Ky. Admin. Regs. 20:400. These provisions belie the notion that such delegation does not involve the use of supervisory authority or independent judgment, at least under conventional and commonly accepted definitions of these terms. As an initial matter, no delegation of nursing tasks may take place under Kentucky regulation(s) without a determination by the delegator that the task can be competently and safely performed by the delegatee, without compromising the patient's welfare. *See* 201 Ky. Admin. Regs. 20:400(3)(2). Furthermore, 201 Ky. Admin. Regs. 20:400(4)(1) specifically provides that such delegation may occur only if the delegating nurse provides "supervision" to the delegatee. The degree of supervision required is a matter for the delegating nurse, who is required to evaluate factors such as: 1) the stability of the patient's condition; 2) the training and competency of the delegatee; 3) the complexity of the nursing task being delegated; 4) the proximity and availability of the delegator to the delegatee. *See* 201 Ky. Admin. Regs. 20:400(4)(2).

kind of judgment exercised by registered nurses in directing. . . nurse's aides in the care of patients occupying skilled and intermediate care beds in a nursing home is not 'merely routine.'").[7] The unpredictability and varied nature of the health care profession—and thus the varied circumstances under which nurses labor—belies any generalized attempt to label a nurse's exercise of supervisory authority routine.[8]

[7] Indeed, the mishandling of a nurse's supervisory tasks could have dire consequences for patients and corresponding significant malpractice liability for the employer in question. Courts have recognized that when disastrous consequences could result from the mishandling of employee oversight responsibilities, such responsibilities cannot simply be swept aside as routine or clerical. *See, e.g. Spontenbush/Red Star Cos. v. NLRB*, 106 F.3d 484, 491 (2d Cir. 1997); *NLRB v. McCullough Envtl. Servs.*, 5 F.3d 923, 941-42 (5th Cir. 1993); *Maine Yankee Atomic Power Co. v. NLRB*, 624 F.2d 347, 356-57 (1st Cir. 1980).

[8] It should be noted that both the Board and the Courts have held that complex tasks, even if performed over and over, are not necessarily "routine" for the purposes of Section 2(11). *See Glenmark Assocs. v. NLRB*, 147 F.3d 333, 341 (4th Cir. 1998) ("The Board mistakenly assumes that because there is an established procedure for handling a particular scheduling situation, nobody is required to think."). For instance, in *Spontenbush*, 106 F.3d at 491-92, a case involving the supervisory status of barge captains, the United States Court of Appeals for the Second Circuit cited *Sun Refining & Mktg. Cos.*, 301 N.L.R.B. 642, 649 (1991) for the proposition that:

> . . . even if a particular operation is performed again and again, it does not necessarily follow that it is routine. . . . Constant monitoring and accountability is essential. Otherwise repetitive operations must be performed under constantly changing conditions which significantly vary the individual components of the operation and the order and the manner in which they are performed. Mistakes can and do result in disastrous consequences . . . .

B. INCREASING DEMAND FOR NURSING SERVICES, DECREASING NUMBERS OF NURSES, AND MOUNTING ECONOMIC PRESSURES REQUIRE EMPLOYERS TO DEPEND UPON NURSES' SUPERVISORY POWERS.

Several factors affecting today's health care employers mandate increasing reliance on nurse supervisors by health care employers. As an initial matter, the demand for nursing services is increasing in the United States at a time in which the supply of nurses is decreasing. On the one hand, as the American Nursing Association noted last year, "aging and an increase in chronic illness will increase the demand for nurses—particularly those with baccalaureate or master's degrees—in hospitals and nursing homes." American Nursing Association, *1999 House of Delegates Summary of Proceedings—Examining the Nursing Workforce*, *at* http://www.nursingworld.org/about/summary/sum99/workforc.htm (last visited Dec. 6, 2000). Furthermore, "[r]apid changes in technology and advances in patient care will increase the demand for nurses over the long term. While technological advances in patient care may reduce the incidence of some diseases, these reductions in morbidity could be offset by increases in the longevity of individuals with chronic illnesses." *Id.*

Despite the increasing demand for nurses, Peter Buerhaus, Director of the Harvard Nursing Research Institute, has predicted that the United States will experience:

> a significant shortage of registered nurses . . . beginning around 2007. Buerhaus foresees a rising demand for registered nurses based on such factors as an aging population, increased longevity of the chronically ill, technological advances, the increased prevalence of antibiotic-resistant infections, cost-cutting pressures of managed care, the shift from high-cost acute care facilities

> to lower cost ambulatory and community-based settings, and increased attention to quality improvement.

Id.[9] Some observers are even less optimistic, and have declared that the nursing shortage crisis is already here:

> Johns Hopkins Hospital . . . can't attract enough nurses to fully staff its operations even though it pays the top salaries in the market and has dramatically increased its use of more-expensive temporary staffing services, says Karen Haller, the hospital's vice president of nursing and patient-care services. . . .
>
> In Southern California, where the nursing shortage is one of the most acute in the country, the few unit closures to date may be just a hint of what is to come. . . .
>
> Hospital managers say they have the greatest difficulty in filling nursing positions in key specialty areas, such as critical-care units, operating rooms and emergency rooms.
>
> . . . . The situation is delivering another financial wallop to an industry already absorbing the shocks of Medicare spending controls, managed-care pressures and failed business strategies. And experts say the situation may not improve even if the economy slows down and employment levels decrease.[10]

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[9] Similarly, the American Hospital Association predicts that, while the supply of RNs currently meets the demand for their services, demand is predicted to outpace supply somewhere between the years 2005 and 2010. *See* American Hospital Association, Trends Affecting Hospitals and Health Systems 54 (2000).

[10] Mary Chris Jaklevic and Ed Lovern, *A Nursing Code Blue: Few Easy Solutions Seen for a National RN Shortage That's Different from Prior Undersupplies*, Modern Healthcare, December 11, 2000, *available at* http://www.modernhealthcare.com/currentissue/topten.php3?refid=6320&db=mh99up&published=200121 (last visited Dec. 16, 2000).

As one commentator sums up the situation, "the United States today is facing shortages of key health personnel, particularly registered nurses . . . ."[11] For this reason, health care employers are increasingly forced to call on nurses to delegate nursing tasks to others—and to supervise others in the execution of those nursing functions.[12]

The incredible economic strain under which many health care providers currently operate is also forcing an increased reliance on nurse supervisors. Increasing operating expenses and frozen or decreasing reimbursements from private health plans and Medicare and Medicaid have subjected American health care providers to the economic equivalent of a one-two knockout punch.[13] Health care costs in the United States are expected to rise from around 10 percent of the gross domestic product in 1990 to approximately 16.6 percent in the year 2007. Rodger Doyle, *Health Care Costs*, Scientific American, April 1999 at 36. The rate of increase of health care costs is more than double the rate of inflation in the United States.[14]

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[11] J. Duncan Moore Jr., *Survey: Nation Facing Shortage of Key Health Personnel Rather Than Predicted Surplus*, HealthLeaders.com, *at* http://www.healthleaders.com/index.cfm?section+9&screen=news&news_id=9922 (last visited Dec. 13, 2000).

[12] *See, e.g.*, G. Roger King, *Where Have All the Supervisors Gone?—The Board's Misdiagnosis of Health Care & Retirement Corp.*, 13 Lab. Law. 343, 357 (1997) (citing *Manor West, Inc. v. NLRB*, 60 F.3d 1195 (6th Cir. 1995)) (further citations omitted).

[13] *See generally*, Bruce Siegel, *Public Hospitals—A Prescription for Survival*, The Commonwealth Fund, October 1996, *at* http://www.cmwt.org/programs/minority/ siegel.asp#abstract (last visited Dec. 19, 2000).

[14] *See Health Care Costs Threaten Middle Class*, *at* http://www.americashealth.org/middle.html (last visited Dec. 17, 2000).

Despite these increases in cost, Congress has been reluctant to adjust reimbursements under Medicare and Medicaid, and even has taken action to cut reimbursements in some health care areas.[15] For example, "[t]he Balanced Budget Act [of 1997] cut a total of $14.3 billion from Medicare's home care budget . . . . In addition, the act instituted a new prospective payment system for nursing homes."[16] Many private health care plans have also refused to increase their reimbursements for increasingly expensive treatments, and some have taken steps to lower their reimbursement rates.[17] As with the reductions in Medicare / Medicaid reimbursements, this trend has subjected hospitals to heretofore unseen economic pressures. Indeed, some hospitals have been forced to cancel their contracts with private insurance providers due to insufficient reimbursement rates. *See, e.g.*, Steve Strunsky, *For Hospital and H.M.O., a Parting of the Ways*, N.Y. Times, Jan. 2, 2000, at 14NJ p. 6 (noting that inadequate reimbursement system caused hospital to cancel its contract with Blue Cross and Blue Shield).

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[15] *See* Robert Kuttner, *The American Health Care System—Wall Street and Health Care*, The New England Journal of Medicine, February 25, 1999 at 664, *available at* http://www.nejm.org/content/1999/0340/0008/0664.asp (last visited Dec. 18, 2000).

[16] *Id.*; *see* 42 U.S.C.A. § 1395u (Balanced Budget Act of 1997); *Greater Dallas Home Care Alliance v. United States*, 10 F. Supp.2d 638, 641 (N.D. Tex. 1998) (holding that Balanced Budget Act's interim payment system was constitutional); *Vermont Assembly of Home Health Agencies v. Shalala*, 18 F. Supp. 2d 355, 371-72 (D. Vt. 1998) (holding that Congress' 1997 budget cuts to home healthcare were constitutional); *see also* Jeanne Schulte Scott, *BBA Bad News Gets Worse, Thanks to Flawed Calculations; Effects of the Balanced Budget Act of 1997 - An Error of 76 Percent in Favor of Medicare*, in Healthcare Financial Management, Sept. 1, 1999, at 24 (arguing that the Balanced Budget Act of 1997 is having a negative impact on the home health industry).

[17] *See* Kuttner, *supra*, note 15, at 664.

Because of these dual financial pressures, health care providers are finding themselves operating in crisis mode. Many large medical systems have reported losing millions of dollars per year, in large part due to reductions in reimbursements.[18] Not surprisingly, an alarming number of large hospital organizations have filed for bankruptcy.[19]

> The nation's second-largest nursing home operator filed for Chapter 11 bankruptcy protection [in January of this year], blaming its misfortune on federal cuts in Medicare reimbursement.
>
> Atlanta-based Mariner Post-Acute Network, which runs more than 400 nursing homes nationwide, said the 1997 Balanced Budget Act had cut its Medicare reimbursement by $115 per nursing home resident.
>
> "The crisis in long-term care continues to grow as dramatic Medicare cuts, explosive litigation costs and staffing shortages threaten the viability of long-term care providers," Mariner chairman Francis Cash said in a statement.

Another Nursing Home Chain Files for Bankruptcy Protection, Fox Market Wire Jan. 18, 2000, *at* http://www.foxmarketwire.com/wires/0118/f_ap_0118_2.sml (last visited Dec. 18, 2000). In addition, a significant number of acute-care hospitals have closed their doors due to the crisis in reimbursement. *See, e.g.*, Gary Shepard, *Number of Hospitals Falls To Record Lows*, LocalBusiness.Com, November 9, 2000, *at* http://www.localbusiness.com/Story/0,118,DDT_501167,00.html (last visited Dec. 18, 2000) (noting that "the

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[18] *See, e.g.*, John Easton, *Teaching Hospitals Feel the Side Effects of Budget Cure*, Univ. of Chicago Magazine, June 1999, *available at* http://www.uchicago.edu/alumni.mag/index.html.

[19] *See* Kuttner, *supra* note 15, at 664.

number of community-based acute-care (non-specialty) hospitals in the United States has dropped below 5,000 . . . for the first time in 25 years" due to sharp revenue losses).

Needless to say, these economic realities force health care providers to make difficult choices. Layoffs are becoming more commonplace as health care institutions experience significant revenue shortfalls.[20] For example, last year Stanford Health Care laid off a number of employees "as a result of an unanticipated $10.7 million budget shortfall."[21] The hospital "attributed the shortfall to decreasing governmental funding of uninsured patients as well as low rates paid by HMOs."[22] Similarly, the University of Pennsylvania Health Care System last year laid off 1,100 employees, accounting for nine percent of the System's total personnel.[23] William N. Kelley, MD, CEO of the Penn Health System, and Dean of the University of Pennsylvania School of Medicine, commented, "This is a very sad day for all of us at the University of Pennsylvania Health System . . . . The combination of government cutbacks; denied, delayed or reduced payments from insurers; and increased amounts of uncompensated care is crippling hospitals and health systems nationwide."[24]

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[20] *See, e.g.*, Jennifer Stewart, *USHC Workers Brace for Layoffs*, The Stanford Daily, (March 10, 1999, *available at* http://daily.stanford.org/Daily98-99/3-10-1999/news/NEWushc10.html (last visited Dec. 18, 2000).

[21] *Id.*

[22] *Id.*

[23] *See* Press Release, *Penn Health Statement*, May 25, 1999, *available at* http://www.upenn.edu/almanac/between/PHEALTH-layoffs.html (last visited Dec. 18, 2000).

[24] *Id.*

To make matters worse, health care institutions are experiencing increased turmoil in their workforces. There is a severe shortage of qualified staff personnel, making the jobs of hospital employees more difficult.[25] Strikes are becoming more and more commonplace. *See, e.g.*, David Kelly, *Health Care Workers Strike at 18 Hospitals, Demand Increases in Pay Labor*, L.A. Times, December 15, 2000 at B2 (reporting that "[t]housands of health care employees who say they are so overworked that patient care suffers walked off the job at 18 hospitals across the state Thursday to press demands for higher pay and increased staffing."). For example, this year 1,200 nurses employed by the Washington Hospital Center in Washington, D.C., staged a strike that lasted more than seven weeks. *See* Avram Goldstein, *Proposal Could End Walkout by D.C. Nurses*, Washington Post, November 7, 2000, at B1.

Perhaps the most serious repercussion of the current economic turmoil facing health care providers is the potential impact on the quality of patient care. As one commentator noted, cutbacks in reimbursement for services "might seriously compromise quality of care." Robert H. Binstock, *Symposium, Public Policies on Aging in the Twenty-First Century*, 9 Stan. L. & Pol'y Rev. 311, 318 (1998). In short, "the pace and nature of' the changes currently experienced in the health care industry "— along with heightened fears of layoffs and staff restructuring—have prompted concerns among RNs that patient care has suffered or will suffer and that the demands placed on nursing staff have led to higher incidences of work-related injuries and stress." Office of News and Public Information, *Hospitals and Nursing Homes Need Changes in*

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[25] *See, e.g.*, Jeff Myers, *Staff Shortage Makes Hard Job More Difficult, Nurses Say*, Press Republican Online, Oct. 29, 2000, *at* http://www.pressrepublican.com/Archive/2000/10_2000/102920002.htm (last visited Dec. 18, 2000).

Mix of Nursing Personnel, at http://www.nationalacademies.org/onpi/pr/jan96/nurse.html (last visited Dec. 12, 2000).

In light of the changes the health care industry has undergone, there is no question but that, in order to deliver high-quality care more efficiently, registered nurses are being granted more and more supervisory powers by their employers. For example, one private California health system, in an effort to economize, recently granted Advanced Practice Registered Nurses ("APRNs") a broad range of duties traditionally reserved to doctors.[26] As a committee of the Institute of Medicine, charged by Congress with investigating the state of nursing in the United States, concluded:

> [i]ncreased pressure to deliver cost-efficient care to patients with more serious and often multiple conditions has forced hospitals to redesign delivery of care and reassess the roles of all nursing personnel. RNs have moved from direct patient care to coordinating and supervising patient care in hospitals . . . . In some institutions, nurse assistants are assuming greater responsibility for direct patient care under RN direction. . . .
>
> Registered nurses with advanced training and skills will [increasingly] be called on to fill roles that require professional judgment, supervision, and direction of the work of others. . . .[27]

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[26] National Health Care Cost & Quality Assoc., *California Long Term Acute Care Hospital System Jettisons in-House Physician Coverage in Favor of Nurse Practitioner Program*, The NHCQA Bulletin, May 5, 2000, *available at* http://www.nhcqa.org/bul2,4.html (last visited Dec. 18, 2000).

[27] Office of News and Public Information, *Hospitals and Nursing Homes Need Changes in Mix of Nursing Personnel*, Jan. 8, 1996, *at* http://www.nationalacademies.org/ onpi/pr/jan96/nurse.html (last visited

According to the Committee Chairperson, "'As hospitals reorganize their staffing mix, continuing education in hospitals and schools should focus more on providing better management tools to nurses, including delegation and supervisory skills. . . .'"[28]

Therefore, given the sea change experienced by the health care industry, health care providers seeking to stay afloat are increasingly turning to cost-efficient nurses to supervise and oversee the delivery of health care. Indeed, one commentator has noted that as nurses in today's health care industry are called upon to "supervise more and more unlicensed personnel" it is increasingly important to provide registered nurses with the "managerial education they need to fulfill their widening roles in the late 1990s and beyond." Kerry Smith, *Back to School: Kaiser Offers Nurses a Chance to Study for BSN and Stay in the Workplace*, Nurseweek, (July 20, 1998), *available at* http://www.nurseweek.com/features/98-7/school.html. The Board's attempt to classify registered nurses as non-supervisory personnel simply ignores the realities of the health care workplace.

C. ENSURING TO EMPLOYERS LOYALTY OF NURSE-SUPERVISORS IS CRUCIAL TO THE HEALTH OF THE HEALTH CARE INDUSTRY

The foregoing demonstrates that many nurses are increasingly called upon to act as supervisors. With good reason, it is the policy of Section 2(11) to permit employers to treat as supervisors those—including nurses—who so act. As this Court has recognized, Section 2(11) is a product of Congress' efforts to preserve an equilibrium of power in the workplace. *See, e.g., Florida Power & Light Co. v. Int'l Bhd.*

Dec. 12, 2000).

[28] *Id.*

of Elec. Workers, Local 641, 417 U.S. 790, 807 (1974); *NLRB v. Winnebago Television Corp.*, 75 F.3d 1208, 1213, 1217 (7th Cir. 1996) ("The structure of [29 U.S.C.] § 152 ensures that employers may rely on supervisors to exercise their independent judgment without the threat of accountability to the employees whom they supervise.").

The legislative history of the Taft-Hartley Act, which added Section 2(11), clearly illustrates this point. Senator Taft, for instance, noted that "[I]t is impossible to manage a plant unless the foremen are wholly loyal to the management." 93 Cong. Rec. 3952 (daily ed. April 23, 1947). The Senate Committee on Labor and Public Welfare noted that "[a] recent development which probably more than any other single factor has upset any real balance of power in the collective bargaining process has been the successful efforts of labor organizations to invoke the Wagner Act for covering supervisory personnel, traditionally regarded as part of management, into organizations composed of or subservient to the unions of the very men they were hired to supervise." S. Rep. No.80-105, at 3 (1947).

Although it was the Senate's definition of supervisor that was ultimately included in the Act, it is worth noting that similar statements regarding the importance of supervisor loyalty were made in the House of Representatives. For instance, the House Committee on Education and Labor noted that employers, "as well as workers, are entitled to loyal representatives in the plants, but when the foreman unionize . . . they are subject to influence and control by the rank and file union, and, instead of their bossing the rank and file, the rank and file bosses them." H.R. Rep. No. 80-245, at 14 (1947). The House Committee concluded that "no one, whether employer or employee, need have as his agent one who is obligated to those on the other side, or one whom, for *any* reason, he does not trust." *Id.* at 17 (emphasis in the original). Importantly, the House Committee specifically listed

[d]octors, *nurses*, [and] safety engineers . . . ." as examples of the types of positions that must remain fully faithful to the interests of the employer, and not the unions. *Id.* at 16 (emphasis added).

The foregoing, in no uncertain terms, reveals Congress' intent that management be assured the complete loyalty of its "front line" supervisory staff. Congress' concerns regarding divided loyalties apply with even more force in the context of the health care profession. As this Court noted in *HCR*:

> [W]e do not share the Board's confidence that there is no danger of divided loyalty here. Nursing home owners may want to implement policies to ensure that patients receive the best possible care despite potential adverse reaction from employees working under the nurses' direction. If so, the statute gives the nursing home owners the ability to insist on the undivided loyalty of its nurses. . . .

HCR, 511 U.S. at 580-81.

Indeed, as Congress envisioned, nurses with divided loyalties will be less effective monitors of unionized caregivers under their supervision. The resulting decrease in oversight and discipline of health care workers endangers not only the safety and welfare of the workers themselves, but undoubtedly will endanger the health and safety of the patients under their care.[29]

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[29] Furthermore, when the quality of care suffers, so suffers the health care provider. Health care providers are increasingly subject to medical malpractice suits, and any factor which inhibits providers' ability to control the quality of patient care will only increase their malpractice risk. *See* Paul L. Scibetta, Note, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends Upon the Health of Hospital Peer Review*, 51 U. Pitt L. Rev. 1025, 1027 (1990) (citations omitted); *see also, e.g.*, *Gahm v. Thomas Jefferson Univ. Hosp.*, No. Civ. A- 94-2050, 2000 WL 233247 at *1 (E.D. Pa. Feb. 29, 2000) (noting that hospitals owe patients a "'nondelegable duty'" to provide quality care) (quoting *Thompson v. Nason Hosp.*, 527 Pa. 330, 339; 591 A.2d 703, 707 (1991)).

II. THE BOARD'S DETERMINATION THAT NURSE SUPERVISORY ACTS BASED UPON JUDGMENTS INFORMED BY PROFESSIONAL KNOWLEDGE, SKILL, OR EXPERIENCE DO NOT MEET THE "INDEPENDENT JUDGMENT" REQUIREMENT OF SECTION 2(11) OF THE NLRA IS IN ERROR.

A. THE TEXT OF SECTION 2(11) DOES NOT SUPPORT THE BOARD'S CONCLUSION.

There is no support in the Act's language for the Board's position that a nurse's supervisory directions to other employees do not meet "independent judgment" requirement of Section 2(11) where such directions, although free of employer constraints, are informed, in whole or in part, by a nurse's own professional or technical skill, knowledge, and experience.[30] As an initial matter, under any commonly

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[30] The Board has presented this case as revolving around the question of whether a nurse's exercise of professional or technical judgment in directing employees "in accordance with employer-specified standards" constitutes the exercise of independent judgment. Brief for the National Labor Relations Board, at (I). SHRM and ASHHRA do not take issue with the proposition that an employer may, in certain instances, so hamstring the exercise of a would-be supervisor's judgment so as to prevent the exercise of "independent" judgment. SHRM and ASHHRA submit that the facts of this case do not demonstrate any "employer-specified standards" that so constrained the exercise of supervisory judgment. In any event, an examination of the numerous Board cases that deny nurses Section 2(11) supervisory status reveals that the Board applies its "professional and technical judgment" approach in cases in which employer constraint of the purported supervisor's judgment is not even arguably an issue. *See, e.g., Providence Hosp.*, 320 N.L.R.B. 717, 729 (1996) ("Section 2(11) supervisory authority does not include the authority of another employee to direct another to perform discrete tasks stemming from the directing employee's experience, skills, training, or position. . . ."); *see also Loyalhanna Health Care Assocs.*, 332 NLRB No. 86, 2000 WL 1670884, at *3 (Oct. 30, 2000); *Elmhurst Extended Care Facilities,*

accepted definition of the term, "independent" means simply not subject to control by others. *See, e.g.*, Webster's New International Dictionary of the English Language, Vol. II, 1262 (2nd ed. 1939) (defining independent as "[n]ot subject to control by others; not subordinate; self-governing; sovereign; free"). This common-sense understanding of the term is bolstered by Section 2(11)'s contrast of exercises of authority involving "independent judgment" and those that merely are "clerical" or "routine"—i.e., those that simply involve the rote implementation of the decisions of others. Thus, under the Act's plain language, judgment unfettered by an employer's or other external constraints, even if informed by the training, experience, and skill that a nurse has worked years to acquire, is independent judgment. *See Beverly Enters., Va., Inc. v. NLRB*, 165 F.3d 290, 298 (4th Cir. 1999) ("[C]ertain types of decisional authority, regardless of the manager's professional knowledge, make one a supervisor under the NLRA.").[31] Indeed, the reason individuals in many instances, and in many industries, are placed in supervisory or management positions is because of factors such as experience, background, training and education. There is no statutory support (or public policy

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329 NLRB No. 55, 1999 WL 801516, at *5 n.9 (Sept. 30, 1999); *Vencor Hosp.-Los Angeles*, 328 NLRB No. 167, 1999 WL 606678, at *5 (Aug. 5, 1999).

[31] This Court, in *HCR*, 511 U.S. at 579, stated in dicta that it was "no doubt true" that the phrase "independent judgment" is "ambiguous" and that the Board needed "ample room to apply [the term] to different categories of employees." *Amici* respectfully disagree with this Court's assessment of the phrase "independent judgment" as ambiguous. In any event, *Amici* submit that the "ample room" described in *HCR* does not provide the authority for "distorting the statutory language in the manner proposed by the Board." *Id.* at 581; *see also Providence Hosp.*, 320 N.L.R.B. at 726 (in which the Board acknowledged that *HCR* held that Section 2(11) must drive Board policy, not the other way around"). Further, as noted *supra*, the Board's "discretion" to date in this area is also extremely poor public policy.

support) for the proposition that health care employers should not have the same rights to select a nurse supervisory workforce.

B. THE BOARD'S INTERPRETATION OF INDEPENDENT JUDGMENT RENDERS OTHER PORTIONS OF SECTION 2(11) MEANINGLESS

The context of the phrase "independent judgment" in Section 2(11) further reinforces the conclusion that the Board's interpretation of the phrase cannot stand. Particularly in the health care field, the Board's false dichotomy between independent judgment and judgment informed by professional skill, experience, or training would effectively render meaningless two of Section 2(11)'s enumerated functions: "assign" and "responsibly to direct."[32] *Cf. HCR*, 511 U.S. at 578-79 (noting that the Board's pre-*HCR* test for supervisory status in nurse-supervisor cases read the responsible direction portion of Section 2(11) out of the statute). As this Court acknowledged in *HCR*, the business of health care employers is the welfare of patients. 511 U.S. at 580.[33] It naturally follows that the assignments and directions from a health care employer to the employees "in the trenches"—i.e. those who actually perform health care services for patients—will be

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[32] *Cf. Allentown Mack Sales & Serv., Inc. v. NLRB*, 522 U.S. 359, 376 (1998) ("Because reasoned decisionmaking demands it, and because the systematic consequences of any other approach are unacceptable, the Board must be required to apply in fact the clearly understood legal standards that it enunciates in principle . . . ."); *Mid-America Care Found. v. NLRB*, 148 F.3d 638, 642 (6th Cir. 1998) (same).

[33] *Cf.* American Health Care Association, Facts & Trends: The Nursing Facility Source Book viii (1999) ("Meeting and improving the quality of life for nursing facility residents through improved service is the top priority for administrators and direct care staff in this decade and will continue to be paramount in the 21st century").

grounded in judgments related to patient care. These judgments, in turn, will be made by persons who possess superior skill, training, and experience regarding patient care. *See, e.g., Schmurmacher Nursing Home v. NLRB*, 214 F.3d 260, 269 (2nd Cir., 2000) ("Managerial power and expertise are often joined together for reasons too obvious to require further explanation, and any effort to treat them as mutually exclusive cannot be squared with the statute."); *NLRB v. Attleboro Assocs., Inc.*, 176 F.3d 154, 167 (3rd Cir. 1999) (noting that "decisions to assign workers are inseverable from independent judgment, especially in the health care context where staffing decisions can have such an important impact on patient health and well-being") (internal quotations and citations omitted). Thus, if judgments based upon superior skill, training, and experience in matters of patient care are not "independent judgments," most—if not all—of the assignments and directions by nurses in the health care field would not be Section 2(11) supervisory decisions.[34]

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[34] Contrary to its contentions, the Board's position that nurses, as a general rule, do not exercise independent judgment in the execution of Section 2(11) functions—including the assignment and direction functions—is a recent phenomenon. Indeed, as the Board itself has admitted, prior to the 1974 Health Care amendments to the Act, "[c]harge nurses were found supervisory" where the facts demonstrated that "they utilized their professional judgment in assigning and directing other employees." *Beverly Enters.—Ohio*, 313 N.L.R.B. 491, 509 n.12 (1993) (citing *Avon Convalescent Ctr.*, 200 N.L.R.B. 702,705 (1972) and *Rockville Nursing Ctr.*, 193 NLRB 959, 962 (1971)). Following the Health Care amendments, the Board reversed itself on the issue, but it did so by adopting the "interest of the employer" test that this Court rejected in *HCR*. *See id.* at 492-93. This test, of course, did not focus on Section 2(11)'s independent judgment prong. *See id.* 493 ("*If* the individual independently exercises supervisory authority, the Board must *then* determine if that authority is exercised 'in the interest of the employer.'") (emphasis added); *id.* at 509 n.12 (reversing *Avon* and *Rockville* as inconsistent with the interests of the employer test). Thus, it was only after *HCR* that the Board adopted its current position vis a vis Section 2(11) in nurse-supervisor cases. *See generally Beverly Enters., Va.*, 165 F.3d at 295-96 (describing—and criticizing—the evolution of Board decisionmaking on the question of supervisory status in the nursing field).

The Board's effective truncation of Section 2(11) poses grave consequences for employers. As an initial matter, perhaps not surprisingly, the "assign" and "responsibly direct" functions are those most usually at issue in nurse supervisor cases. *See* Wilma B. Leibman & Peter J. Hurtgen, *The Clinton Board(s)—A Partial Look From Within*, 16 Lab. Law. 43, 48 (2000) ("While health care employers make a variety of supervisory arguments, the question usually boils down to whether the charge nurses have the statutory authority to 'assign' or 'responsibly direct' other employees.").[35] Thus, the Board's approach to Section 2(11) effectively ensures that virtually no nurse will be deemed to be a "supervisor" under the Act. Furthermore, for many hours of the day in many long-term care facilities and in many discrete areas or departments of acute-care hospitals, nurses are the highest ranking employees on duty—and thus the only representative of an employer "in charge." *See Glenmark Assocs., Inc. v. NLRB*, 147 F.3d 333, 341 (4th Cir. 1999); *Grancare, Inc. v. NLRB*, 137 F.3d 372, 376 (6th Cir. 1998). Therefore, if the Board's purported distinction between judgments based upon "independent judgments" and judgments based upon a nurse's skill, experience, and training is allowed to stand—and thus if the assignments and directions of nurses are not Section 2(11) supervisory activities—health care employers must simply accept the curious notion that their institutions operate for long

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[35] *Cf. Attleboro*, 176 F.3d at 160 (noting the Board's "biased mishandling of cases involving supervisors") (internal quotations and citations omitted); *Spontenbush/Red Star Cos. v. NLRB*, 106 F.3d 484, 492 (2nd Cir. 1997) (noting "the Board's manipulation of the definition of supervisor"); *Winnebago Television*, 75 F.3d at 1214 (same); *Schnuck Mkts., Inc. v. NLRB*, 961 F.2d 700, 704 (8th Cir. 1992) (same); *NLRB v. St. Mary's Home, Inc.*, 690 F.2d 1062, 1067 (4th Cir. 1982) (same).

stretches without effective supervision, essentially on auto-pilot. This, of course, is contrary to the purposes of Section 2(11), *see, e.g., Florida Power & Light Co.*, 417 U.S. 790, 808 (1974) (noting that employers are entitled to loyal representatives in their facilities), and to common sense, *see, e.g., Glenmark Assocs.*, 147 F.3d at 341 ("We cannot fathom the Board's position that for more than two-thirds of the week at a nursing home providing twenty-four hour care, where patient conditions can change on a moment's notice, there is no one present at the facility exercising independent judgment regarding proper staff levels and patient assignments."); *Grancare*, 137 F.3d at 376 (noting that an interpretation of Section 2(11) that would mean that a nursing home had no on-site supervision almost half the time was not a reasonable conclusion for a well-run nursing home).[36]

C. THE BOARD'S INTERPRETATION OF INDEPENDENT JUDGMENT IS NOT NECESSARY TO RESOLVE "TENSION" BETWEEN SECTIONS 2(11) AND 2(12)

The Board argues that its current interpretation of the term "supervisor" is necessary to reconcile Congress' exclusion of supervisors in Section 2(11) and its inclusion of professionals in Section 2(12). *See* Brief of the National Labor Relations Board, at 32-35. This is not the case. As an initial matter, the purported tension between Section 2(11) and Section 2(12) should not be overstated. It is, of course, true

[36] *Cf. Empress Casino Joliet Corp. v. NLRB*, 204 F.3d 719, 721 (7th Cir. 2000) ("[T]he Board's ruling has the curious implication that a ship with more than 1000 people aboard it . . . has no supervisor on board *at any time*, making the situation, in the Board's view, a little like that of the *Patna* in Conrad's novel *Lord Jim* after the crew abandoned it.") (emphasis in the original); *Schnuck Markets*, 961 F.2d at 706 ("Nor is it a reasonable conclusion to suppose that Schnucks would operate one of its largest stores for eight hours every day with twelve to sixteen employees on staff without on-site supervision.").

that professional employees are covered by the Act and supervisors are not. It is also true that some of the language in Section 2(11) is roughly paralleled in Section 2(12). Section 2(11) defines a supervisor, in part, as one who uses independent judgment in the execution of one or more enumerated activities. Section 2(12) defines a professional employee, in part, as one who uses "discretion and judgment" in the exercise of his or her duties. As Member Cohen pointed out in his dissent in *Providence Hosp.*, however, the distinction between the two sections is "substantial and real." 320 N.L.R.B. 717, 737 (1996) (Cohen dissenting). A professional exercises discretion and judgment with respect to tasks that he or she performs. A supervisor, on the other hand, exercises independent judgment with respect to the tasks listed in Section 2(11) and vis-a-vis employees. *See, e.g., Attleboro Assocs.*, 176 F.3d at 168 ("There is an obvious distinction between exercising independent judgment or acquired skill in completing a task, on the one hand, and using independent judgment in performing one of the 12 section 2(11) tasks, on the other."). Thus, by way of example, the task of devising a treatment plan involves the use of professional judgment. The task of implementing that plan, however, may involve the exercise of supervisory responsibilities vis-a-vis employees who actually carry out the plan. In some instances the task of creating the plan and the task of implementing the plan may be lodged in the same person, but this will not always be the case. Thus, as the Second Circuit stated in *Schnurmacher Nursing Home*, 214 F.3d at 268:

> It may be the case that one who makes a judgment about the need for certain actions based on specialized knowledge and experience and exercises no further authority is not a statutory supervisor. But where the responsibility to make such a judgment and to see that others do what is required by that judgment are lodged in one person, that person is a quintessential statutory supervisor.

In any event, to the extent that there is tension between Sections 2(11) and 2(12), this does not entitle the Board to "distort[] the statutory language" of Section 2(11) to resolve this tension. *HCR*, 511 U.S. at 581. This Court has made clear that "[t]he Act does not distinguish professional employees from other employees for the purposes of the definition of supervisor in § 2(11)." *Id.*; *see also Attelboro Assocs.*, 176 F.3d at 168 ("Consequently, it is impossible to comprehend how a nurse's status as a professional employee negates her status as a supervisor."). The Board may not avoid a straightforward and textually honest application of Section 2(11) in nurse-supervisor cases simply because it dislikes the results. *See Providence Hosp.*, 320 N.L.R.B. at 726 (acknowledging this Court's command that "Section 2(11) must drive Board policy, not the other way around").

D. THE LEGISLATIVE HISTORY OF SECTION 2(11) DOES NOT SUPPORT THE BOARD'S CONCLUSION

The legislative history of the Taft-Hartley Act also makes clear that an employee, who in the directions of others, uses judgment unfettered by the employer but informed by the employee's skill, knowledge and experience uses independent judgment for the purposes of Section 2(11). Following the adoption of Senate Report No. 105, Senator Flanders successfully proposed an amendment which added Section 2(11)'s "responsibly to direct" language. Senator Flanders' comments on the proposed language not only illustrate the reasons behind the amendment, they also illustrate proper interpretation of the phrase "independent judgment."

> Many of the activities described in paragraph (11) are transferred in the modern practice to a personnel manager or department. The supervisor may recommend more or less effectively, but the personnel department may, and often does, transfer a worker to another department on

> other work instead of discharging, disciplining or otherwise following the recommended action.
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> In fact, under some management methods the supervisor might be deprived of authority for most of the functions enumerated [in Section 2(11)] and *still have a large responsibility for the exercise of personal judgment based on personal experience, training, and ability*. He is charged with the responsible direction of his department and the men under him. He determines under general orders what job shall be undertaken next and who shall do it. He gives instructions for proper performance. If needed, he gives training in the performance of unfamiliar tasks to the worker to whom they are assigned.
>
> Such men are above the grade of "straw bosses, lead men, set-up men, and other minor supervisory employees. . . ." Their essential managerial duties are best defined by the words "direct responsibly," . . . .
>
> In a large measure, the success or failure of a manufacturing business depends on the judgment and initiative of these men. The top management may properly be judged by its success or failure in picking them out and in backing them up when they have been properly selected.

93 Cong. Rec. 4804 (daily ed. May 7, 1947) (statement of Sen. Flanders) (emphasis added).

Notwithstanding Senator Flanders' statement, the Board and *Amici* supporting the Board's position argue that nurses are the equivalent of "straw bosses" or "leadpersons." The Board and such *Amici* are vague as to the definitions of these terms, however, most likely because the applicable definitions belie any claim that nurses qualify as such. For example, the term "straw boss" is derived from the logging industry:

> In the early days of logging in mountainous country straw was spread upon slopes too steep for horses to hold back a sled load of logs. . . . After each passage, sometimes at a full gallop to keep the horses ahead of the load, the straw was naturally displaced so a man with a pitchfork was posted at each slope to keep the straw evenly distributed. Although teamsters were men of consequence in the lumber camps, the rule was that they were not to start down a slope until the far humbler functionary with a pitchfork, using his "independent judgment," passed word that the slope was prepared. . . . *Perhaps a modern counterpart would be an attendant at a company parking lot with the authority to direct higher-ups in the organization with respect to parking their cars.*

NLRB v. Swift & Co., 292 F.2d 561, 563 n.2 (1st Cir. 1961) (emphasis added). The Board cannot possibly argue that the majority of nurses in this country are merely "functionar[ies] with a pitchfork" providing limited direction to "higher-ups" in one basic task.[37]

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[37] Similarly, a "leadperson" is a craftsperson or other low-level skilled employee "whose primary function is physical participation in the production or operating processes of [his or her] employer['s] plants and who *incidentally direct[s] the movements and operations of less skilled subordinate employees.*" *Southern Bleachery & Print Works, Inc.*, 115 N.L.R.B. 787, 791 (1956) (emphasis added). The instructions of leadpersons are "inherent in the craftsman-helper relationship." *Id.* The Board cannot argue that nurses' supervisory direction of those within their charge is merely an "incidental" portion of nurses' duties. Rather, supervision and direction of others is a primary responsibility for many of today's nurses. Furthermore, it is somewhat remarkable that the Board attempts to argue, on the one hand, that nurses are not Section 2(11) supervisors because they are Section 2(12) professionals (i.e. "persons of consequence" employed to exercise judgment) while arguing simultaneously that nurses are not Section 2(11) supervisors because they are lowly straw bosses or leadpersons.

Senator Flanders thus offered his amendment because, without it, Section 2(11)'s definition of supervisor "cover[ed] adequately everything except the basic act of supervising"—providing responsible direction to other employees, using "personal judgment based on personal experience, training, and ability." *Id.* Yet, judgments based on "personal experience, training, and ability" are the very judgments that the Board currently asserts are not "independent" judgments under the Act. The Board's position on this point is simply wrong.[38]

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[38] Senator Flanders indicated the reasons that those who provide responsible direction based upon "personal experience, training, and ability" are rightly considered supervisors under Section 2(11).

> The reasons are simple and direct. Unless the employer can hire and discharge, promote, demote, and transfer these men, he has lost control of his business. He cannot run it effectively. If he cannot run it effectively and efficiently, he cannot continue in business profitably. If he cannot operate profitably, he is a bad manager, not only from the stockholders' standpoint, but also from that of the working force as well. Only a profitable business can furnish sustained employment at good wages. At this point the interests of stockholders and employees are identical.

93 Cong. Rec. 4804 (daily ed. May 7, 1947) (statement of Sen. Flanders). These words apply with even more force in a health care setting, where patient care is the employer's business. *See HCR*, 511 U.S. at 577-78 (finding no distinction acts taken in connection with patient care and acts taken in the interests of the employer). Where the Board impedes the employer's ability to properly run a health care institution, patient well-being—not simply the bottom line—is jeopardized.

CONCLUSION

For the foregoing reasons, the judgment of the United States Court of Appeals for the Sixth Circuit should be affirmed.

Respectfully submitted,

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